54 Fam. Ct. Rev. 250

Family Court Review
April, 2016

Additional Article

Susan Ainsley McCarter [a1]

HOLISTIC REPRESENTATION: A RANDOMIZED PILOT STUDY OF WRAPAROUND SERVICES FOR FIRST-TIME JUVENILE OFFENDERS TO IMPROVE FUNCTIONING, DECREASE MOTIONS FOR REVIEW, AND LOWER RECIDIVISM [1]

Abstract

Mental health diagnoses, substance abuse issues, and school problems are often cited as contributors to adolescents' involvement with the juvenile justice system. Yet, few youth receive assessment, evaluation, or intervention prior to their involvement with the juvenile courts. This pilot study evaluated whether providing a randomized trial of wraparound forensic social work services in addition to court-appointed legal services would improve functioning, decrease motions for review, and lower recidivism for first-time juvenile offenders. Findings indicate statistically significant improvement for youth receiving wraparound services on six out of eight measures. A case study example is provided and implications for service provision are explored.

Key Points for the Family Court Community:

• Many youth enter the juvenile justice system with underlying and unaddressed risk factors such as mental health issues, substance abuse challenges, or school problems.

• Unfortunately, most adolescents' mental health, substance abuse, and educational challenges have not been identified or treated prior to contact with the juvenile justice system.

• Court-appointed lawyers may meet defense representation needs, but holistic representation services can bolster existing client strengths/protective factors and address the underlying needs/risk factors which weaken youth functioning and contribute to additional court involvement and/or reoffending.

Keywords: *Delinquency: Forensic Social Work; Juvenile Offenders; Legal Representation: Race Disparity; Recidivism; and Wraparound Services*.

INTRODUCTION

In 2013, over 30 million youth in the United States were under the jurisdiction of the juvenile justice system (Hockenberry & Puzzanchera, 2015). During that year, departments of juvenile justice processed 1,058,500 new cases with more than half (55%; 582,200) of the cases handled with formal petitions through juvenile court. Despite proportionate self-reported criminal activity, delinquency cases are disproportionate. In 2013, White youth comprised 76% of the U.S. juvenile population, but were underrepresented in their proportion of delinquency cases at 62%; as were Asian youth (including Native Hawaiian and Other Pacific Islander) with 6% of the population but only 1.2% of delinquency cases; and American Indian youth with 2% of the population but 1.6% of delinquency cases. Only African American youth were overrepresented; comprising 16% of the U.S. juvenile population but 35.3% of the delinquency cases. Moreover, male youth comprised 72% of those delinquency cases in 2013, whereas female youth comprised 23% and 53% of all delinquency cases involved ***251** youth 15 years old or younger. The risk and protective factors affecting juvenile delinquency are varied and complex, but juvenile justice scholars often cite mental health challenges (e.g., Gordon, Diehl, & Anderson, 2012; Shufelt & Cocozza, 2006; Teplin, Abram, McClelland, Washburn, & Pikus, 2005), substance use (e.g., Chassin, 2008; Mendel, 2011), and school problems (e.g., Fabelo et al., 2011) as contributors, whereas practitioners seek evidence-based interventions to weaken the risk factors and bolster the protective factors.

BACKGROUND

National studies estimate that 10-22% of juveniles in the general population have mental health needs (Cocozza & Skowyra, 2000; Friedman, Katz-Leavy, Manderscheid, & Sandheimer, 1996). For youth in the juvenile justice system, the prevalence of mental health needs is much higher (Goldstrom, Jaiquan, Henderson, Male, & Mandersheid, 2000; Pullmann et al., 2006; Teplin, Abram, McClelland, Dulcan, & Mericle, 2003). One study estimates that two-thirds of juveniles in detention facilities meet the criteria for one or more mental health disorders, and about 20% of the youth in custody have a mental health disorder severe enough to limit their ability to function (Shufelt & Cocozza, 2006). Mood disorders (e.g., clinical depression) are estimated to occur in 10-25% of youthful offenders (Teplin et al., 2003). In adolescence, mood disorders, attention-deficit hyperactivity disorder (ADHD), and conduct disorder (CD) have been associated with irritability, hostility, belligerence, impulsivity, and anger, which all contribute to the potential for aggressive or delinquent behavior (Grisso, 2008; Jones & Foster, 2009). Moreover, Wasserman, McReynolds, Ko, Katz, and Schwank (2005) suggest that violent female offenders are five times more likely than male offenders to present with anxiety disorders, and among youth diagnosed with conduct disorder, female offenders are more likely to have occurring internalizing disorders and more complex diagnoses (Wasserman et al., 2005).

Substance use disorders and substance-related issues are also directly correlated with juvenile delinquency (Kilpatrick et al., 2013; Teplin et al., 2003). Statutorily, possession and use of substances by adolescents constitutes delinquency. The National Institute on Drug Abuse (NIDA) reports that 56% of young men and 40% of young women test positive for drugs at the time of their arrest (NIDA, 2006). A 2010 national survey of youth confined in detention facilities found that "[m]ore than two-thirds reported serious substance abuse problems, and 59 percent said that they had been getting drunk or high several times per week (or daily) in the months leading up to their arrest" (Mendel, 2011, p. 24).

Similarly, youth in the juvenile justice system face, school problems at higher rates than other youth, and have notably higher rates of learning disabilities, truancy, suspensions, and dropouts (Cavendish, 2013; Fabelo et al., 2011). Quinn, Rutherford, Leone, Osher, and Poirier's (2005) national study found that students with disabilities are up to four times more likely to be found in the juvenile justice system as compared to students without disabilities. Another recent study found that adolescents with lower levels of emotional engagement at school were more likely to engage in delinquency (Li et al., 2011). Engagement includes positive relationships with peers and teachers and involvement in academic or school-based social activities (Fredricks, Blumenfeld, & Paris., 2004). When young people are unable to make connections with others or their school, they risk developing antisocial attitudes or behavior, which may lead to detachment and delinquency (Li et al., 2011).

Many American youth face a combination of these difficulties (Chassin, 2008), all within a rapidly developing, but not fully developed brain (Giedd, 2008), which adds to the complexity. Data from the National Longitudinal Study of Adolescent Health suggest that mental health and school factors serve as both risk and protective factors for involvement in violence during

adolescence (Bernat, Oakes, Pettingell, & Resnick, 2012). Factors protecting youth from violence involvement were: low ADHD symptoms, low emotional distress, high educational aspirations, and high grade-point average; whereas risk factors for violence involvement were: early ADHD symptoms, low school ***252** connectedness, low grade-point average, and high peer delinquency (Bernat et al., 2012). Unfortunately, most adolescents' mental health, substance abuse, and educational challenges have not been identified or treated prior to contact with the juvenile justice system (Teplin et al., 2005; Wasserman et al., 2005). One study of young people in the Juvenile Division of the Illinois Department of Corrections showed that less than half of youth who had a clinical substance use disorder reported ever receiving treatment (Johnson et al., 2004). For many young people, their entry into the juvenile justice system represents the first time these needs are ever identified.

WRAPAROUND FORENSIC SOCIAL WORK SERVICES FOR OFFENDERS

Wraparound service provision was developed in the 1980s as a response to the fragmentation of human services systems (Pullmann et al., 2006; Snyder, Lawrence, & Dodge, 2012; Wilson, 2008). The wraparound approach provides a collaborative and coordinated response of service providers that organizes and streamlines service delivery. It is strengths-based, family-centered, and culturally sensitive; tailoring each service plan to the individual client and his/her needs, values, and talents (Snyder et al., 2012). Forensic social work is most broadly defined as practice with diverse populations impacted by legal issues both civil and/or criminal (Maschi & Killian, 2011). Wraparound service provision requires a team-based approach that includes the child, family, and service providers in developing, implementing, and evaluating each part of the plan (Carney & Buttell, 2003; Wilson, 2008).

Studies examining the impact of wraparound forensic social work services for youthful offenders have shown mixed results. Bickman, Smith, Lambert, and Andrade (2003), for example, found no consistent differences between groups on outcome measures, though Carney and Buttell (2003) found that youth who received wraparound services were less likely to engage in subsequent at-risk and delinquent behavior. Similarly, Pullmann, et al. (2006) concluded that youth enrolled in coordinated mental health treatment within a juvenile justice system are “less likely to recidivate at all, are less likely to recidivate with a felony offense, and will serve less detention time” (p. 394). Pullmann and his colleagues (2006) recommended that wraparound services include multilevel interventions which consider all of the domains of an adolescent's life, including mental health, family, school, and community. Using case studies of adolescent boys, Myaard, Crawford, Jackson, and Alessi (2000) found that after receiving wraparound forensic social work services, youth showed improvements in compliance, peer interactions, physical aggression, alcohol/drug use, and extreme verbal abuse. Haber, Cook, and Kilmer (2012) noted that providing wraparound services is often more difficult for older youth than for younger children; however, providing youth with wraparound services may also produce “unique benefits” that can empower them to enact individual- *and* systemic-level changes (Haber et al., 2012, p. 464). Finally, in his meta-analysis of effective interventions with juvenile offenders, Mark Lipsey (2009) suggests that “therapeutic” interventions or ones with counseling and multiple service approaches (e.g., wraparound service provision, Multi-Systemic Therapy) were found to be more effective than other types of interventions. Thus, the general consensus of researchers and practitioners is that “wraparound services are superior to standard methods of care for troubled youth” (Wilson, 2008, p. 3).

PURPOSE

The purpose of the current study was to assess whether providing wraparound forensic social work services, in addition to, existing legal defense services would improve youth functioning, decrease Motions for Review (MFRs), and decrease recidivism for first-time juvenile offenders in a large Southeastern city. The researchers used a randomized experimental design where the treatment group received both legal defense services and social work services while the control group received only legal defense services (Treatment as Usual [TAU]). Youth functioning was measured by the ***253** Achenbach System of Empirically Based Assessment (ASEBA) Youth Self-Report (YSR), mandated court reappearances by the total number of MFRs, and recidivism was measured by the number of days between the first petition filed and any second petition filed during the 12-month study period. It was hypothesized that first-time juvenile offenders' scores on the YSR would improve for those in the holistic representation program (HRP), whereas offenders' scores from the control group would either stay the same or decline

from pretest to posttest and that youth in the treatment group would have fewer MFRs and more days in between first petition and second petition.

METHOD

Individuals were assigned case numbers using a random number generator that blinded researchers, attorneys, social workers, and participants to subjects' placement in either the treatment or control group. All agency staff members administering the YSRs were trained on how to use the instrument and all were master's-level prepared. The agency providing legal representation covers all indigent defense services for youth in the county, so 100% of the youth who were eligible for a court-appointed attorney, and who met the inclusion criteria during the course of the study, were invited to participate as they entered the system on a rolling basis. Inclusion criteria were: first-time offenders, ages of 11-16, and assignment to an agency attorney; whereas exclusion criteria were: prior offenses or a diversion contract, current mental health commitments, undisciplined designation, or limited English proficiency.

Once assigned a case from the treatment group, a social worker met with the youth and his/her family, explained the project (using a script prepared with Institutional Review Board review and approval), inquired about voluntary participation, obtained informed assent from the youth and parental consent, and administered the ASEBA YSR as a pretest of youth functioning. Social workers also attended team meetings assembled on behalf of the youth (e.g., school Individual Education Plan meetings, child-family team meetings). Based on their overall assessment, the social workers then provided wraparound services which included: attending any team meetings with or on behalf of youth; providing service referrals; and connecting families and guardians to local providers for appropriate mental health, substance abuse, and educational services and support. When needed, they also arranged for physical health services at the local health care clinic that served as the adolescent's medical home. In particular, the social workers assisted family members to insure that referrals and recommendations were completed and treatment goals were set with families and youth.

The study was conducted over the course of 1 year. On the start date (date that the juvenile first met with the attorney or social worker) the juvenile was pretested using the YSR at either the courthouse or initial visit to the legal offices. Posttests were then conducted 6 months after the youths' start dates also at either the courthouse or legal offices. Measures of functioning (YSRs), number of MFRs, dates of initial petitions, and dates of subsequent petitions (if any) were collected for members of both treatment and control groups.

MEASURES

Functioning was assessed using the ASEBA YSR, a 112-item psychological assessment instrument that contains scales oriented to the *Diagnostic and Statistical Manual of Mental Disorders*. The YSR measures competence, somatic complaints, anxiety and depression, social problems, thought problems, attention problems, delinquent rule-breaking behaviors, aggressive behaviors, internalizing, and externalizing. Internal consistency ranges from .55 to .95 and test-retest reliability values range from .82 to .88. Criterion validity for the YSR was measured by multiple regressions, odds ratios, and discriminant analyses all of which showed significant ($p < .01$) discrimination. The YSR has been nationally normed, including for use with multicultural, low socioeconomic status, and court-involved youth. MFRs were measured by simple count of any motions filed during the study ***254** period. Recidivism was measured by the number of days between the first petition filed, and any subsequent petition filed during the 12-month study period. MFR and recidivism data were provided by the court; insomuch as this study was a collaborative effort between the university, the community agency/service provider, and the courts.

PARTICIPANTS

Fifty-one of the 121 juvenile offenders who sought legal representation met the study's inclusion criteria. Twenty-six juvenile offenders were randomly provided treatment assignment numbers, and 25 were randomly assigned numbers indicating their

membership in the control group for only legal representation/treatment as usual. Three youth or their parents/guardians declined to participate in the study. Four youth started the pretest but were unable to complete it; two were called into court and two got sick. Of the 40 remaining youth, all completed the pretest, but only 29 completed the posttest (seven had their cases dropped, three moved, and one had his case transferred to adult court) with the majority being in the treatment group (by random assignment).

The treatment group receiving "holistic representation"/wraparound forensic social work services had 22 study participants and the control group had seven. Therefore, the researchers employed a detailed analysis using intention-to-treat principles and strategies. All youth who sought services during the study period and who met the inclusion criteria were invited to participate thus, protecting the inferential basis of statistical analysis provided for in randomization. Secondly, given the reasons for withdrawal and nonparticipation, no selection bias preference for the treatment group is apparent. Finally, despite the fact that more youth randomly assigned to the control group did not complete the pre- and posttests, the two groups did not differ significantly on any of the independent or prognostic variables measured (see the sample comparison statistics below).

The mean age for the treatment group was 14.59 (*SD* = .6661, range = 13-16 years) and the mean age for the control group was 14.22 (*SD* = .7868, range = 13-15 years). The majority of the sample was in the eighth or ninth grade. In the treatment group, one youth (4.5%) was in the seventh grade, seven (31.8%) were in the eighth grade, eight (40.9%) were in the ninth grade, and five (22.8%) were in the tenth grade. The control group had one youth (14.3%) in the seventh grade, three (42.9%) in the eighth grade, two (28.5%) in the ninth grade, and one (14.3%) in the tenth grade. The treatment group was 68.2% African American (*n* = 15), 22.8% Caucasian (*n* = 5), 4.5% "Other" (*n* = 1), and 4.5% (*n* = 1) "Did Not Answer." The control group was 71.4% African-American (*n* = 5), 14.3% Caucasian (*n* = 1), and 14.3% "Did Not Answer" (*n* = 1). In the treatment group, 18 of the 22 youth identified as male (81.8%) and 4 identified as female (18.1%); in the control group 6 identified as male (85.7%) and 1 as female (14.3%). Although the control group was smaller than planned, systematic error was ruled out mathematically. No nonrandom attrition was found per intention to treat analysis, and the members of the control group did not differ in any significant ways from the treatment group based on measures of face value.

ANALYSES

A pretest-posttest randomized experimental design was used to evaluate holistic wraparound service provision. Preliminary analyses were conducted to verify independent groups and examine correlations between pretest and posttest scores. Based on the research design and procedures, maturation and history were not considered to be major threats to internal validity, nor was the interaction of pretesting and treatment considered to be a major threat to external validity. Analysis of variance was not employed because using only gain scores could be considered a weak analysis for this design (Dimitrov & Rumrill, 2003), so analysis of covariance (ANCOVA) was used. Treatment and control groups were compared with social work services as the experimental stimulus, posttest scores as the outcome, and pretest scores as the covariate. ANCOVA was used to determine whether there were ***255** significant differences between the treatment and control groups' YSR posttest scores following the intervention.

RESULTS

The assumption of independence was met with youth randomly assigned to either group, and analysis of the demographic variables notes no meaningful difference between the two groups and no significant difference between their YSR pretest scores. This nonfinding supports the notion that neither of the groups differed in any meaningful way from the other, and that no one group was already trending towards significant improvement.

For the control group (*n* = 7) across all eight scales on the YSR (*n* = 56 data points/scores), 29 scores improved, 21 worsened, and 6 exhibited no change from pretest to posttest (see Figure 1). Higher scores on the YSR indicate a higher incidence of problem behaviors. In this sample, 12 youth had scores in the clinical range on at least one scale, and 14 had borderline-clinical scores on at least one scale.

TABULAR OR GRAPHIC MATERIAL SET FORTH AT THIS POINT IS NOT DISPLAYABLE
Figure 1 Control Group Pre- and Posttest YSR Scores

Comparing treatment group pretest scores with posttest scores, across all eight scales (anxious/depressed, withdrawn/depressed, somatic complaints, social problems, thought problems, attention ***256** problems, rule-breaking behaviors, aggressive behaviors) on the YSR (n = 176 data points/scores), 101 scores improved, 32 worsened, and 43 exhibited no change from pretest to posttest (see Figure 2).

TABULAR OR GRAPHIC MATERIAL SET FORTH AT THIS POINT IS NOT DISPLAYABLE
Figure 2 Treatment Group Pre- and Posttest YSR Scores

Comparing the treatment group's posttest mean scores to the control group's posttest mean scores, the treatment group showed significant improvement for youth functioning on six out of the eight scales (see Table 1). Significant differences were found on the: Withdrawn/Depressed (F = 13.784, p < .000), Somatic Complaints (F = 6.964, p < .004), Thought Problems (F = 6.91, p < .004), Attention Problems (F = 9.845, p < .001), Rule-Breaking Behavior (F = 5.953, p < .007), and Aggressive Behavior scales (F = 12.125, p < .000). However, differences on two scales, Anxious/Depressed (F = 2.802, p < .079) and Social Problems (F = .867, p < .432) were not significant.

TABLE 1

COMPARISON OF THE EIGHT SUBSCALE MEAN SCORES ON THE YOUTH SELF REPORT PRE- AND POSTTESTS FOR THE TREATMENT AND CONTROL GROUPS AND ANALYSES OF COVARIANCE

	PRETEST SCORES		***POSTTEST SCORES***			
	Mean	*SD*	*Mean*	*SD*	*F*	p
Anxious/Depressed Subscale						
Treatment Group (n = 22)	54.86	4.95	51.63	2.83	2.802	.079
Control Group (n = 7)	53.42	4.07	55.71	8.80		
Withdrawn/Depressed Subscale						

Treatment Group (n = 22)	57.36	7.61	54.50	5.77	13.784	.000
Control Group (*n* = 7)	61.57	6.13	61.00	5.09		
Somatic Complaints						
Treatment Group (*n* = 22)	57.40	7.77	54.31	5.52	6.964	.004
Control Group (*n* = 7)	55.71	3.54	56.28	8.01		
Social Problems						
Treatment Group (*n* = 22)	53.63	4.43	52.54	5.09	.867	.432
Control Group (*n* = 7)	56.85	4.81	53.57	3.50		
Thought Problems						
Treatment Group (*n* = 22)	56.59	5.84	53.54	3.39	6.91	.004
Control Group (*n* = 7)	53.85	4.52	53.85	3.93		
Attention Problems						
Treatment Group (*n* = 22)	56.09	5.61	52.09	3.50	9.845	.001
Control Group (*n* = 7)	57.14	7.33	56.42	6.52		
Rule-Breaking Behavior						
Treatment Group (*n* = 22)	58.09	5.53	55.18	5.78	5.953	.007
Control Group (*n* = 7)	61.85	8.55	59.28	5.18		
Aggressive Behavior						
Treatment Group (*n* = 22)	56.59	7.26	51.04	6.60	12.125	.000
Control Group (*n* = 7)	58.42	3.30	58.14	5.55		

The two additional measures, MFRs and recidivism, did not yield significant results. Five (22.7%) of the 22 youth in the treatment group had MFRs during the 12-month study period compared to four (57.1%) out of the seven youth in the control group. Two (9%) youth from the treatment group committed new offenses, and one (14.2%) youth from the control group committed new offenses during the study period.

DISCUSSION

This pilot study assesses the impact of holistic representation/wraparound forensic social work services on first time offenders' functioning, MFRs, and recidivism. With few data points, limited conclusions can be drawn from the differences between the treatment and control groups on MFRs and recidivism. But findings from the YSR as pretest and posttest, ANCOVAs suggest that when wraparound forensic social work services were added to legal representation services (TAU), youth ***257** functioning improved significantly on scales measuring withdrawal/depression, somatic complaints, thought problems, attention problems, rule-breaking behaviors, and aggressive behaviors. These significant differences occurred despite the fact that the control group was a TAU group with the same level of legal services as the treatment group. Neither treatment nor control groups showed significant improvements on the Anxious/Depressed or Social Problems scale; this may be attributed to the complexities of trauma and their correlation to anxiety and depression in youth (Maschi, 2006) and the typical transitions of adolescence (McCarter, 2013).

Though some youthful offenders have been classified as unable or unwilling to be rehabilitated (Payne, Tewksbury, & Mustaine, 2010), the vast majority may be receptive to holistic representation programs designed to help them address any substance abuse or mental health challenges, engage in school, and choose alternative paths to delinquency. The social workers in this study provided referrals to community service providers for mental health services, enrollment in substance abuse treatment groups or work with individual substance abuse counselors, and connection to physical health services through the local teen health clinic/patient-centered medical home (PCMH) for adolescents. The majority of their time, however, was spent building individual rapport/relationships with the youth and their families and advocating for their clients in the schools. Of the three broad categories of mental health challenges, substance abuse issues, and school problems, particular attention to school problems for this population may be warranted given educational trends in the U.S. referred to in the literature as the school-to-prison pipeline (Christie, Jolivette, & Nelson, 2005; Fabelo et al., 2011). Moreover, in many jurisdictions, schools have become the primary referral source to both Departments of Social Services and Departments of Juvenile Justice (Race Matters for Juvenile Justice, 2011).

LIMITATIONS

Although randomization and the fact that researchers, attorneys, social workers, and participants were blind to youths' assignment were certainly strengths; the generalizability of these findings is limited by the small sample, particularly in the control group. Because those in the sample population were all provided a court-appointed attorney, there was little socio-economic variation and wealthier adolescents were not in the study. The research also only included juvenile offenders and this may have affected the likelihood of recidivism (Van Fleet, Davis, DeWitt, Byrnes, & Barusch, 2003). In addition, as is consistent with national statistics, the majority of the study participants were youth of color (Leiber & Rodriguez, 2011; McCarter, 2011) suggesting that a race-analysis would have been helpful. Finally, the work was cross-sectional and provides insight only into limited points in time, at the baseline and then 6 months following the baseline data collection; a longitudinal study may better examine the duration of wraparound service and its effect on youth functioning, MFRs, and ultimately, recidivism.

CASE STUDY EXAMPLE--SAVAN'S STORY

Savan (a fictitious name for an actual youth in the study) and her family relocated from Laos when she was an infant. Although she spoke English as her primary language, her parents were still, learning. Savan experienced a “normal” early childhood, but recalled feeling isolated from her peers beginning in middle school. Students teased her, made fun of her, and physically bullied her. Savan said that at this time she began self-mutilating, and often thought about suicide. Her parents reported that they did not know how to help her. They were not familiar with the community or its services, and they did not think anything would be culturally relevant to help Savan.

The HRP social worker first met Savan and her family at a detention hearing after Savan was charged with assault with a deadly weapon at school. Witness reports suggested that the fight happened after a week-long incident of bullying. The social worker scheduled a physical and a ***258** psychiatric assessment at the participating teen clinic/PCMH. The social worker also assisted Savan and her family at the school hearing on her charges. Savan and her family noted that this was extremely helpful as her parents have limited English proficiency and there was no offer to secure a translator. The social worker was able to slow the meeting/process down so that both Savan and her mother understood the process related to the charge. Savan thrived at the teen clinic/PCMH and within a few months she was transitioned into a dialectical behavior therapy group to continue to address her depression and self-injuries. The following year, she began school at the local alternative school. Savan excelled there as a model student, was able to complete all of her community service hours, and was successfully discharged from probation.

CONCLUSION AND IMPLICATIONS

Many youth enter the juvenile justice system with underlying and unaddressed risk factors such as mental health issues, substance abuse challenges, or school problems. Juvenile justice scholars contend that mental health, substance abuse, and

school problems are underassessed and undertreated in the juvenile justice system because of a lack of resources, lack of trained staff, and a punishment mentality (Roberts & Bender, 2006). At the same time, many argue that the juvenile justice system has become the default mental health service provider for youth with serious mental illness, substance abuse, or school problems (Goldstrom et al., 2000; Pullmann et al., 2006). Despite its limitations, this study provides evidence of the effects of wraparound forensic social work services for first-time juvenile offenders. Unlike previous studies, which advocated for assessment through Juvenile Assessment Centers (Dembo, Schmeidler, & Walters, 2004) or through screening tools (Roberts & Bender, 2006), this research provides empirical support for the effectiveness of both assessment *and* service provision for court-involved youth. Court-appointed lawyers may meet defense representation needs, but holistic representation services can bolster existing client strengths/protective factors and address the underlying needs/risk factors which weaken youth functioning and contribute to additional court involvement and/or reoffending.

REFERENCES

Bernat, D. H., Oakes, J. M., Pettingell, S. L., & Resnick, M. (2012). Risk and direct protective factors for youth violence: Results from the National Longitudinal Study of Adolescent Health. *American Journal of Preventive Medicine, 43*(2), 57-66.

Bickman, L., Smith, C., Lambert, E. W., & Andrade, A. R. (2003). Evaluation of a congressionally mandated wraparound demonstration. *Journal of Child and Family Studies, 12*, 135-156.

Carney, M. M., & Buttell, F. (2003). Reducing juvenile recidivism: Evaluating the wraparound services model. *Research on Social Work Practice, 13*, 551-568.

Cavendish, W. (2013). Academic attainment during commitment and postrelease education-related outcomes of juvenile justice-involved youth with and without disabilities. *Journal of Emotional and Behavioral Disorders, 22*, 41-52.

Chassin, L. (2008). Juvenile justice and substance use. *The Future of Children, 18*, 165-183.

Christie, C. A., Jolivette, K., & Nelson, C. M. (2005). Breaking the school to prison pipeline: Identifying school risk and protective factors for youth delinquency. *Exceptionality, 13*(2), 69-88.

Cocozza, J. J., & Skowyra, K. R. (2000). Youth with mental health disorders: Issues and emerging responses. *Office of Juvenile Justice and Delinquency Prevention Journal, 3*, 3-13.

Cocozza, J. J., Skowyra, K. R., & Shufelt, J. L. (2010). *Addressing the mental health needs of youth in contact with the juvenile justice system in system of care communities: An overview and summary of key issues*.

Washington, DC: Technical Assistance Partnership for Child and Family Mental Health. Retrieved from http://www.tapartnership.org/docs/jjResource_overview.pdf

***259** Dembo, R., Schmeidler, J., & Walters, W. (2004). Juvenile assessment centers: An innovative approach to identify and respond to youths with substance abuse and related problems entering the justice system. In A. R. Roberts (Ed.), *Juvenile justice sourcebook: Past, present, and future* (pp. 512-536). New York: Oxford University Press.

Dimitrov, D. M., & Rumrill, P. D. Jr. (2003). Pretest-posttest designs and measurement of change. *Work, 20*, 159-165.

Fabelo, T., Thompson, M. D., Plotkin, M., Carmichael, D., Marchbanks, M. P., & Booth, E. A. (2011). *Breaking schools' rules: A statewide study of how school discipline relates to students' success and juvenile justice involvement*. New York: Council of State Governments Justice Center.

Friedman, R. M., Katz-Leavy, J. W., Manderscheid, R. W., & Sandheimer, D. L. (1996). Prevalence of serious emotional disturbances in children and adolescents. In R. W. Manderscheid & M. A. Sonnenschein (Eds.), *Mental health, United States* (pp. 71-89). Washington, DC: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.

Fredricks, J. A., Blumenfeld, P. C., & Paris, A. H. (2004). School engagement: Potential of the concept, state of the evidence. *Review of Educational Research, 74*, 59-109.

Giedd, J. (2008). The teen brain: Insights from neuroimaging. *Journal of Adolescent Health, 42*, 335-343.

Goldstrom, I., Jaiquan, F., Henderson, M. J., Male, A., & Manderscheid, R. W. (2000). The availability of mental health services to young people in juvenile justice facilities: A national survey. In R. W. Manderscheid & M. J. Henderson (Eds.), *Mental health, United States, 2000* (pp. 248-268). Washington, DC: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

Gordon, J. A., Diehl, R. L., & Anderson, L. (2012). Does ADHD matter? Examining attention deficit and hyperactivity disorder on the likelihood of recidivism among detained youth. *Journal of Offender Rehabilitation, 51*, 497-518.

Grisso, T. (2008). Adolescent offenders with mental disorders. *The Future of Children, 18*, 143-164.

Haber, M. G., Cook, J. R., & Kilmer, R. P. (2012). Perceptions of family environment and wraparound processes: Associations with age and implications for serving transitioning youth in systems of care. *American Journal of Community Psychology, 49*, 454-466.

Hockenberry, S., & Puzzanchera, C. (2015). *Juvenile court statistics 2013*. Pittsburgh, PA: National Center for Juvenile Justice.

Johnson, T. P., Cho, Y. I., Fendrich, M., Graf, I., Kelly-Wilson, L., & Pickup, L. (2004). Treatment need and utilization among youth entering the juvenile corrections system. *Journal of Substance Abuse Treatment, 26*, 117-128.

Jones, D. E., & Foster, E. M. (2009). Service use patterns for adolescents with ADHD and comorbid conduct disorder. *The Journal of Behavioral Health Services and Research, 36*, 436-449.

Kilpatrick, D. G., Ruggiero, K. J., Acierno, R., Saunders, B. E., Resnick, H. S., & Best, C. L. (2013). Violence and risk of PTSD, major depression, substance abuse/dependence, and comorbidity: Results from the national survey of adolescents. *Journal of Consulting and Clinical Psychology, 71*, 692-700.

Leiber, M., & Rodriguez, N. (2011). The implementation of the disproportionate minority confinement/contact (DMC) mandate: A failure or success? *Race and Justice*, 7(1), 103-124.

Li, Y., Zhang, W., Liu, J., Arbeit, M. R., Schwartz, S. J., Bowers, E. P., et al. (2011). The role of school engagement in preventing adolescent delinquency and substance use: A survival analysis. *Journal of Adolescence, 34*, 1181-1192.

Lipsey, M. W. (2009). The primary factors that characterize effective interventions with juvenile offenders: A meta-analytic overview. *Victims and Offenders, 4*, 124-147.

Maschi, T. (2006). Unraveling the link between trauma and male delinquency: The cumulative versus differential perspectives. *Social Work, 51*, 59-70.

Maschi, T., & Killian, M. L. (2011). The evolution of forensic social work in the United States: Implications for 21st century practice. *Journal of Forensic Social Work*, 7(1), 8-36.

McCarter, S. A. (2011). Disproportionate minority contact in the American juvenile justice system: Where are we after 20 years, a philosophy shift, and three amendments? *Journal of Forensic Social Work*, 7(1), 96-107.

McCarter, S. A. (2013). Adolescence. In E. Hutchison (Ed.), *Essentials of human behavior: Integrating person, environment, and the life course* (pp. 545-589). Thousand Oaks, CA: Sage.

Mendel, R. (2011). *No place for kids: The case for reducing juvenile incarceration*. The Annie E. Casey Foundation. Retrieved from http://www.aecf.org/OurWork/JuvenileJustice/JuvenileJusticeReport.aspx

Myaard, M. J., Crawford, C., Jackson, M., & Alessi, G. (2000). Applying behavior analysis within the wraparound process: A multiple baseline study. *Journal of Emotional and Behavioral Disorders, 8*, 216-229.

National Institute on Drug Abuse. (2006). Principles of drug abuse treatment for criminal justice populations: A research-based guide. NIH Publication No. 06-5316, National Institutes of Health.

Payne, B. K., Tewksbury, R., & Mustaine, E. E. (2010). Attitudes about rehabilitating sex offenders: Demographic, victimization, and community-level influences. *Journal of Criminal Justice, 38*, 580-588.

Pullmann, M., Kerbs, J., Koroloff, N., Veach-White, E., Gaylor, R., & Sieler, D. (2006). Juvenile offenders with mental health needs: Reducing recidivism using wraparound. *Crime Delinquency, 52*, 375-397.

Quinn, M. M., Rutherford, R. B., Leone, P. E., Osher, D., & Poirier, J. M. (2005). Youth with disabilities in juvenile corrections. *Exceptional Children, 71*, 339-345.

Race Matters for Juvenile Justice. (2011). www.rmjj.org

Roberts, A. R., & Bender, K. (2006). Mental health disorders and recidivism among juvenile delinquents. *Federal Probation, 70*(2), 19-28.

***260** Shufelt, J., & Cocozza, J. (2006, June). Youth with mental health disorders in the juvenile justice system: Results from the multi-state prevalence study. Research and program brief, National Center for Mental Health and Juvenile Justice.

Skowyra, K., & Cocozza, J. (2007). *Blueprint for change: A comprehensive model for the identification and treatment of youth with mental health needs in contact with the juvenile justice system*. Delmar, NY: National Center for Mental Health and Juvenile Justice.

Snyder, E. H., Lawrence, C. N., & Dodge, K. A. (2012). The impact of system of care support in adherence to wraparound principles in child and family teams in child welfare in North Carolina. *Children and Youth Services Review, 34*, 639-647.

Teplin, L. A., Abram, K. M., McClelland, G. M., Dulcan, M. K., & Mericle, A. A. (2003). Psychiatric disorders in youth in juvenile detention. *Archives of General Psychiatry, 59*, 1133-1143.

Teplin, L. A., Abram, K. M., McClelland, G. M., Washburn, J. J., & Pikus, A. K. (2005). Detecting mental disorder in juvenile detainees: Who receives services? *American Journal of Public Health, 95*, 1773-1780.

Van Fleet, R. K., Davis, M. J., DeWitt, J., Brynes, E. C., & Barusch, A. (2003). *Evaluation of Utah's early intervention mandate: Juvenile sentencing guidelines and intermediate sanctions, 1996-2000*. Inter-University Consortium for Political and Social Research, 2003. Ann Arbor, MI.

Wasserman, G. A., McReynolds, L. S., Ko, S. J., Katz, L. M., & Schwank, J. (2005). Gender differences in psychiatric disorder for youths in juvenile probations. *American Journal of Public Health*, 95(1), 131-137.

Welch-Brewer, C. L., Stoddard-Dare, P., & Mallett, C. A. (2011). Race, substance abuse, and mental health disorders as predictors of juvenile court outcomes: Do they vary by gender? *Journal of Child and Adolescent Social Work, 28*, 229-241.

Wilson, K. J. (2008). *Literature review: Wraparound services for juvenile and adult offender populations*. Davis, CA: Center for Public Policy Research.

Footnotes

1 This study was supported in part by a Faculty Research Grant at the University of North Carolina Charlotte.

a1 *Susan McCarter, Ph.D., MS, MSW, has been a forensic social work practitioner, Disproportionate Minority Contact (DMC) researcher and scholar, and anti-racist advocate for over 20 years. Her career began working with adolescents as a mental health counselor and juvenile probation officer and then a policy analyst and advocate in Richmond, VA, where she earned her MSW (clinical) and her Ph.D. (social policy and social work) from Virginia Commonwealth University. Her area of emphasis is adolescent risk and protective factors--specifically race/ethnicity and involvement with the juvenile justice, child welfare, education, and health care systems. She*

is currently an associate professor of social work at the University of North Carolina Charlotte and serves as vice president of the National Organization of Forensic Social Work, associate editor for the Journal of Forensic Social Work, leadership team member of Race Matters for Juvenile Justice, and active member of the NC Disproportionate Minority Contact Subcommittee.

54 FAMCR 250